May 23, 2024

The Honorable Vern Buchanan
Chairman
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1100 Longworth HOB
Washington, DC 20215

The Honorable Lloyd Doggett
Ranking Member
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1100 Longworth HOB
Washington, DC 20215

Re: MGMA Statement for the Record — House Committee on Ways and Means Subcommittee on Health Hearing, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"

Dear Chairman Buchanan and Ranking Member Doggett:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing on the challenges facing independent medicine. Numerous policies and extraneous factors coalesce to undermine the ability of independent medical groups to remain financially viable — cuts to Medicare reimbursement, staffing shortages across clinical and nonclinical positions, substantial administrative burden, inflation, and more. We appreciate the Subcommittee for examining policies that can help bolster independent practices who remain a bedrock of our healthcare system.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

Independent practices are vital to the communities they serve yet are rapidly becoming extinct. Over the past decade, physicians fed up with government overregulation, payer red-tape, and declining reimbursement have sold their practices to health systems, hospitals, insurers, and private equity firms at an alarming rate. They cannot survive as small businesses. Health systems can maintain reserves to weather the next economic storm. Most independent practices can't carry cash reserves year-over-year or they would face double taxation. It's common for hospital systems to run medical practices as a loss-leader, often at yearly losses in excess of $200,000 or more per FTE physician. They subsidize the shortfalls with more lucrative revenue from inpatient services, health insurance plans, and ancillary referrals. If many of these system-owned physician practices were run independent from non-ambulatory subsidies, they would quickly go out of business. This environment illustrates a broken system that forces independent practices to make difficult decisions about their ownership structure and erodes their ability to stay in operation.

Exacerbating these concerns are the effects of multiple significant events over the past several years. The COVID-19 Public Health Emergency (PHE) had a seismic impact, not only on the nation's health system, but especially on independent physician groups. Even with the flexibilities and financial relief programs implemented by multiple administrations, independent physician groups that were already operating on razor thin margins were particularly affected by the reduced patient volume and increased costs resulting from the pandemic.

Further amplifying these impacts is the ongoing fallout from the massive Change Healthcare cyberattack. Change Healthcare provides a multitude of services to the industry, touching one in three patient records and processing 15 billion healthcare transactions annually.[1] MGMA members felt numerous negative impacts following the cyberattack, including: severe billing and cash flow disruptions, inability to submit claims, limited or no electronic remittance advice (ERA) from health plans, electronic prescriptions could not be transmitted, lack of connectivity to data infrastructure, health information technology disruptions, and much more.[2] To even get paid, physician practices had to institute workarounds for various processes to remain operational, which required significant labor costs and time to institute, diverting critical resources from patient care. The impacts are still being felt and affecting independent practices' ability to keep their doors open. Smaller, independent practices were far more vulnerable than their larger corporate brethren.

Taken together, these major events illuminate the precarity underlying independent physician practices. In addition, MGMA surveys our members annually for our regulatory burden report, and 75% of respondents to our 2023 report were independent practices. Throughout our testimony we highlight these burdens and offer policy solutions to support independent practices' ability to thrive and provide high-quality care to their communities.

Key Recommendations

- **Provide an annual inflation-based physician payment update based on the Medicare Economic Index (MEI) and modernize the budget neutrality aspect of Medicare payment.** Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023,* which would provide a long-needed annual Medicare physician payment update tied to inflation, as measured by the MEI. Congress needs to also mitigate the negative impact of the antiquated budget neutrality requirements of the Medicare Physician Fee Schedule (PFS) by enacting the *Provider Reimbursement Stability Act of 2023*.
- **Make commonsense changes to the Merit-based Incentive Payment System (MIPS)** such as alleviating the program's reporting burden, and extending the Small, Underserved, and Rural Support (SURS) program that expired in 2022.
- **Reduce administrative burden by implementing prior authorization reform.** Prior authorization burden is particularly felt by independent practices that have less resources to devote to onerous administrative processes than larger health systems. Congress should enact an updated version of the *Improving Seniors' Timely Access to Care Act* to alleviate prior authorization burden, which has historically been the number one regulatory burden facing

[1] Department of Health and Human Services, Letter to Health Care Leaders on Cyberattack on Change Healthcare, March 10, 2024.
[2] MGMA Statement for the Record – Senate Committee on Finance Hearing, "Hacking America's Health Care: Assessing the Change Healthcare Cyber Attack and What's Next," May 1, 2024.

medical groups. The *GOLD CARD Act* and the *Reducing Medically Unnecessary Delays in Care Act* would make additional needed reforms to the prior authorization process if passed into law.

- **Work to address the physician shortage** by properly funding Graduate Medical Education (GME) programs and increasing Medicare-supported medical residency positions.
- **Provide positive financial incentives to support independent practices transitioning into value-based care.** Congress should extend the Alternative Payment Model (APM) incentive bonus at 5%, provide resources to assist practices with the transition into APMs, and allow the Centers for Medicare & Medicaid Services (CMS) the ability to set the qualifying participant threshold at an appropriate level that does not discourage APM participation. Numerous provisions in the *Value in Health Care Act of 2023* would help address these concerns.
- **Support the development of physician-led, value-based care models** designed to help independent medical groups succeed.
- **Examine further authorities and flexibilities** that should be granted to federal agencies so they can rapidly respond to future cyberattacks and significant events to support independent physician practices' ability to keep their doors open.

Stabilizing Medicare Payment

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) replaced the sustainable growth rate formula with the Quality Payment Program (QPP). This was intended to stabilize payment rates in the Medicare fee-for-service (FFS) system and incentivize physicians to transition into value-based payment models. The QPP created two reporting pathways to facilitate the transition to value-based care: the Merit- based Incentive Payment System (MIPS) and advanced alternative payment models (APMs).

In addition to no annual positive payment update, independent medical groups also experience annual reimbursement cuts stemming from 2021 PFS changes and correlating budget neutrality requirements. CMS finalized a 3.37% cut to the Medicare conversion factor in its 2024 Medicare PFS; from Jan. 1 to March 8 of this year, medical groups absorbed a 3.37% reduction to reimbursement. Following congressional action to partially mitigate 1.68% of the cut in the *Consolidated Appropriations Act of 2024* (CAA, 2024), physician practices are left with a 1.69% reduction for the rest of the year.

These ongoing cuts are untenable for practices and must be averted to ensure the financial viability of independent medical groups. The 2024 Medicare Board of Trustees' annual report outlines the inadequacy of Medicare payment and its potential impact on Medicare participation: "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation … Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."[3] This echoes what medical groups are saying, with 87% of groups reporting reimbursement not keeping up with inflation impacts current and future Medicare patient access.[4]

In the face of ongoing Medicare cuts, the cost of running a medical practice continues to rise — according to MGMA data, physician practices saw total operating cost per FTE physician increase by over 63%

[3]2024 Medicare Board of Trustees Annual Report, May 6, 2024.
[4] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023.

from 2013–2022, while the Medicare conversion factor increased by only 1.7% over the same timeframe. Eighty-nine percent of medical groups reported an increase in operating costs in 2023.[5]

An annual inflation-based physician payment update tied to inflation, as measured by the MEI, is needed to prevent further damage to independent medical groups' ability to continue operating. Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023* — this bipartisan bill introduced by congressional doctors currently has 142 cosponsors and is essential to ensuring independent groups are reimbursed fairly to prevent them from shutting down.

Further, MGMA recommends the Committee work to mitigate the harmful impact of Medicare's budget neutrality requirements. The *Provider Reimbursement Stability Act of 2023* would modernize many aspects of Medicare budget neutrality and would make significant changes to alleviate the adverse effects practices are experiencing. The legislation would increase the triggering threshold from $20 million to $53 million (while adding an update to keep pace with inflation), institute new utilization review requirements to better reflect the reality of providers using certain services compared to CMS' estimates, and more.

MGMA urges Congress to make changes to budget neutrality in unison with the long-needed annual inflationary update. The current policies work in concert to undercut the financial viability of medical practices, as independent medical groups will be facing another cut in 2025 absent congressional intervention.

Reducing burden in the Quality Payment Program

MIPS Reform

MACRA instituted the Quality Payment Program (QPP) that includes MIPS which was intended to be an on-ramp in the transition to value-based care for medical groups to join APMs. Unfortunately, the program has been beset with issues. Physician practices cannot continue to divert financial and staff resources away from patient care to comply with duplicative MIPS requirements. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities and MIPS cost practices $12,811 per physician to participate.[6] Aside from onerous reporting requirements that do not drive meaningful clinical improvements and unfairly penalize clinicians, the $500 million funding for the MIPS exceptional performance bonus expired at the end of 2022. MGMA urges Congress to extend the exceptional performance bonus, which will support physician practices as they work to comply with MIPS requirements.

Rural, small, and medically underserved independent practices can be disproportionally disadvantaged under MIPS. The SURS program provided direct support for these practices, but funding appropriated under MACRA expired in February 2022. MGMA encourages Congress to extend this critical program by passing the *SURS Extension Act*, as it is needed to assist practices in rural and underserved areas understand the continuously changing policies in MIPS and succeed in the program.

There are many factors contributing to increased administrative burden under MIPS for independent practices. The MIPS program requires clinicians to report on quality measures that are not clinically

[5] MGMA Stat Poll, July 12, 2023.
[6] Dhruv Khullar, Amelia Bond, Eloise May O'Donnell, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System*, Jama Network, May 14, 2021.

relevant to them. The cost reporting measure holds clinicians accountable for costs outside of their control. It is a time-consuming and laborious process to comply with these requirements. Compounding these issues is the lack of adequate and timely feedback by CMS on measure performance. Without receiving appropriate feedback about which patients are assigned to them and what costs outside of their practice they must account for, physicians are unable to correct issues and improve compliance.

A study from the Weill Cornell Medical College found that MIPS scores inconsistently relate to performance on process and outcome measures.[7] The study found that physicians treating more medically complex patients were more likely to receive low MIPS scores despite providing high-quality care. Medical groups report that MIPS reporting requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities. The QPP reporting burden is substantial — 67.19% of MGMA members surveyed for the 2023 annual regulatory burden report found QPP reporting to be extremely or very burdensome.[8]

Small independent practices are disproportionately impacted by MIPS policies as they often do not have the same resources, staff, and capital as large systems. In 2022, the Small, Underserved, and Rural Support (SURS) technical assistance program ended due to a lack of congressional funding. This program was vital in assisting small practices' compliance with the constantly evolving policies in MIPS, and its expiration further exacerbates small practices' ability to meet program requirements. The *SURS Extension Act* would help rectify this problem by reinstating the program.

CMS proposed to increase the MIPS performance threshold from 75 points in 2023 to 82 points in the 2024 proposed Medicare Physician Fee Schedule (PFS). While we are thankful the agency maintained the current threshold at 75 points, this number is already too high, and a further increase of the threshold would result in even more physician practices receiving a negative adjustment.

Supporting innovative value-based care models

APM Development

Value-based care (VBC) models must be designed to address the challenges facing independent practices if CMS wants to meet its goal of having every Medicare beneficiary in an accountable care arrangement by 2030. There are numerous barriers preventing independent groups from both joining and successfully participating in VBC arrangements due to application requirements and parameters around many of the CMS Innovation Center (CMMI) models. Seventy-eight percent of medical groups reported that Medicare does not offer an Advanced APM that is clinically relevant to their practice, with 56% of members being interested in participating in a clinically relevant model if one were to exist.[9] The Congressional Budget Office found that accountable care organizations (ACOs) led by independent physician groups were

[7] Amelia M. Bond, PhD; William L. Schpero, PhD; Lawrence P. Casalino, MD, PhD, Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes, JAMA Network, Dec. 6, 2022.
[8] *Supra* note 4.
[9] *Supra* note 4.

associated with greater savings, thereby demonstrating the value of expanding access to these arrangements.[10]

CMMI and private sector entities under the Physician-Focused Payment Model Technical Advisory Committee (PTAC) can develop APMs. Unfortunately, CMMI, who possess the sole responsibility to test and implement the APM, has yet to test any of the models PTAC has recommended.

In conjunction with a shortage of APMs, 94% of MGMA members reported that moving to value-based care initiatives has not lessened the regulatory burden on their practices.[11] This is exemplified by recently finalized changes in the 2024 PFS that added burdensome Promoting Interoperability reporting requirements in the Medicare Shared Savings Program (MSSP), as well as certified health information technology utilization requirements that are set to take effect in 2025. One of the main benefits of joining an APM is the reduced MIPS reporting burden — these policies undermine the success of groups joining value-based care arrangements.

APM Incentive Payment and Qualifying Participant Threshold

Shifting program requirements and financial incentives instituted under MACRA do not align with enabling independent practices to successfully participate in APMs. Congress recently extended the APM incentive payment at 1.88% for 2024 — a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to cover costs, support investments, and safeguard the financial viability of medical groups in the program.

Further, the qualifying participation (QP) threshold to participate in an APM is unreasonably high. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS; it was set to increase this year, but Congress intervened by freezing the threshold in the *Consolidated Appropriations Act of 2023.* Practices should not be subject to an excessively high threshold that fosters uncertainty and hinders their ability to participate — MGMA supports giving CMS the flexibility to adjust the QP threshold so that it is not set arbitrarily high. The *Value in Health Care Act of 2023* would work to address the APM incentive payment and QP threshold problems facing practices.

Reducing prior authorization burden

Prior authorization requirements are routinely identified by medical groups as the most challenging and burdensome obstacle to running a practice and delivering high-quality care. Increasing prior authorization requirements are detrimental to both practices and the patients they treat. Prior authorization requests disrupt workflow, increase practice costs, and result in dangerous denials and delays in care. In 2018, MGMA partnered with several provider groups and health plans to publish a *Consensus Statement on Improving the Prior Authorization Process*.[12] Our organizations agreed that selective application of prior authorization, volume adjustment, greater transparency and communication, and automation were areas of opportunity to improve upon. However, since the time this consensus statement was released, medical groups have reported little progress in any of these areas.

---

[10] Congressional Budget Office, Medicare Accountable Care Organizations: Past Performance and Future Directions, April 16, 2024.
[11] *Supra* note 4.
[12]MGMA, AHA, AHIP, AMA, APhA, BlueCross BlueShield Association, *Consensus Statement on Improving the Prior Authorization Process*, Jan. 1, 2018.

MGMA is increasingly alarmed by reports of rising prior authorization requirements — 89% of medical groups assert that prior authorization requirements are very or extremely burdensome.[13] Ninety-two percent of physician practices reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests. Sixty percent of groups reported that there were at least three different employees involved in completing a single prior authorization request.[14] Physician practices are already facing significant workforce shortage issues — this situation is simply untenable.

Despite feedback from MGMA to multiple administrations and Congress over the years regarding the unnecessary administrative burden, cost, and delay of treatment associated with prior authorization, CMS has only recently begun to finalize regulations to mitigate some of these harms. While the agency's actions are a good first step, there is still more work to be done as these requirements disproportionally impact small businesses and medical groups who do not have the resources, infrastructure, and personnel to process these prior authorization requests.

The *Improving Seniors' Timely Access to Care Act*, which we anticipate will soon be reintroduced, would make welcomed changes to ease this burden. Previous iterations of this legislation had widespread bipartisan, bicameral support with over 53 Senators and 327 Representatives cosponsoring the bill in 2022. We strongly urge Congress to pass this long-needed legislation, as well as the *GOLD CARD Act*, the *Reducing Medically Unnecessary Delays in Care Act* as these bills would make additional critical reforms.

Improving the healthcare workforce

MGMA has been a longtime champion of increased funding and reasonable improvements to the GME program as the U.S. healthcare system will face a shortage of up to 86,000 physicians by 2036.[15] We appreciate the progress Congress has made over the past few years adding Medicare-funded GME slots through the *Consolidated Appropriations Acts of 2021 and 2023*, but there is still a critical need for more doctors to treat our nation's aging population.

The *Resident Physician Shortage Reduction Act of 2023* is bipartisan legislation that would help address the physician shortage facing the nation, which is especially pronounced in rural communities. This bill would increase Medicare-supported medical residency positions by 14,000 over the course of seven years. These slots are a lifeline to ensuring patients have access to care and we urge the Committee to support its passage.

There are additional critical workforce challenges as staffing shortages across clinical and nonclinical positions remain a concern for medical group practices. Fifty-six percent of medical groups reported staffing as their biggest productivity roadblock in an April 18, 2023, MGMA *Stat* poll.[16] As Congress continues to examine ways to bolster the healthcare workforce, MGMA hopes the Committee will take a comprehensive view of the staffing concerns facing medical groups to better strengthen the workforce programs under its purview.

---

[13] *Supra* note 4.
[14] MGMA, Spotlight: Prior Authorization in Medicare Advantage, May 2023.
[15] Association of American Medical Colleges, The Complexities of Physician Supply and Demand: Projections from 2021 to 2036, Mar. 2024.
[16] MGMA *Stat* poll, Apr. 20, 2023.

A major contributor to the healthcare workforce shortage is the worsening problem of physician and staff burnout, with 65% of physicians having reported experiencing burnout in 2022.[17] Many of the issues discussed in this letter compound to increase burnout — when you add prior authorization requirements that MGMA members consistently rank as their number one regulatory burden on top of these issues, it only hastens staff resignations and employee turnover. Practices are already facing significant workforce shortage issues — this situation is simply unsustainable.

Conclusion

MGMA thanks the Subcommittee for its leadership in examining the issues undermining independent medical groups. We look forward to working with you to craft commonsense policies that will allow independent physician practices to continue providing high-quality patient care. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

[17]Jackson Physician Search and MGMA, Back from Burnout: Confronting the Post-Pandemic Physician Turnover Crisis, Oct. 7, 2022.